

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>005017</b>             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/30/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ELKHART GENERAL HOSPITAL</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>600 E BLVD</b><br><b>ELKHART, IN 46514</b> |  |  |
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| S 000   | <p>INITIAL COMMENTS</p> <p>The visit was for investigation of two State hospital complaints.</p> <p>Complaint Number:<br/>IN 00151869<br/>Unsubstantiated: lack of sufficient evidence.<br/>Deficiencies cited unrelated to the allegations</p> <p>Complaint Number:<br/>IN000152053<br/>Substantiated: deficiencies cited related to the allegations</p> <p>Date: 7-29/30-14</p> <p>Facility Number: 005017</p> <p>Surveyor: Brian Montgomery, RN, BSN<br/>Public Health Nurse Surveyor</p> <p>QA: cloughlin 08/12/14</p> | S 000  |  |  |
| S 330   | <p>410 IAC 15-1.4-1 GOVERNING BOARD</p> <p>410 IAC 15-1.4-1(c)(6)(K)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following:<br/>(6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(K) Maintaining personnel records for each employee of the hospital which include personal data, education and experience, evidence of participation</p>   | S 330  |  |  |

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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| S 330   | <p>Continued From page 1</p> <p>in job related educational activities,<br/>and records of employees which relate<br/>to post offer and subsequent physical<br/>examinations, immunizations, and<br/>tuberculin tests or chest x-ray, as<br/>applicable.</p> <p>This RULE is not met as evidenced by:<br/>Based on document review and interview, the<br/>facility failed to follow its policy/procedure and<br/>maintain its personnel records regarding the post<br/>job offer screening documentation of immunity to<br/>communicable disease for 1 of 9 personnel files<br/>(N17) reviewed and maintain documentation<br/>indicating that a responsible person reviewed the<br/>post job offer screening results for 6 of 9<br/>personnel files (N12, N13, N14, N15, N18 and<br/>N19) reviewed.</p> <p>Findings:</p> <p>1. The policy/procedure Post Job Offer<br/>Screening Process (approved 5-14) indicated the<br/>following: "Confirm Chickenpox immunity or need<br/>for vaccination ...confirm Hepatitis B immunity or<br/>need for vaccination for all associates who are at<br/>risk for blood and body fluid exposure ...The PJO<br/>(post job offer) screening will be conducted by a<br/>Medical Assistant under the supervision of [a]<br/>licensed Registered Nurse, RN Manager and<br/>Physician Medical Director OR by a licensed<br/>Registered Nurse under the Physician Medical<br/>Director."</p> <p>2. A review of the personnel health record for<br/>staff N17 failed to indicate documentation of<br/>immunity to chickenpox (varicella) or hepatitis B<br/>virus.</p> | S 330  |  |  |

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| S 330   | Continued From page 2<br><br>3. During an interview on 7-30-14 at 1005 hours, employee health manager A10 confirmed that the personnel health file lacked documentation of immunity to chicken pox or hepatitis B virus.<br><br>4. A review of the personnel health records for staff N12, N13, N14, N15, N18 and N19 failed to indicate documentation that a responsible person had reviewed the communicable disease screening results<br><br>5. During an interview on 7-30-14 at 1005 hours, employee health manager A10 confirmed that the 6 personnel health files lacked documentation indicating that the screening results had been reviewed by a licensed staff or medical assistant in accordance with facility policy. | S 330  |  |  |
| S 418   | 410 IAC 15-1.4-2 QUALITY ASSESSMENT AND IMPROVEMENT<br><br>410 IAC 15-1.4-2(b)(1)(2)<br><br>(b) The hospital shall take appropriate action to address the opportunities for improvement found through the quality assessment and improvement program as follows:<br><br>(1) The action shall be documented.<br><br>(2) The outcome of the action shall be documented as to its effectiveness, continued follow-up and impact on patient care.<br><br>This RULE is not met as evidenced by:<br>Based on document review and interview, the  | S 418  |  |  |

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| S 418   | <p>Continued From page 3</p> <p>hospital failed to maintain and ensure its policy/procedures were followed regarding the investigation and review of an adverse patient event and failed to identify and correct a lapse in its incident management process for 1 of 455 patient events (patient 27) reviewed.</p> <p>Findings:</p> <p>1. The policy/procedure Incident Reporting System (approved 2-13) indicated the following: "Incident reports...are to be checked by immediate supervisor and/or the unit manager or director...the risk manager will conduct RCA (root cause analysis)/Intensive Assessment and report to the Patient Safety Committee..." The policy/procedure failed to indicate a process or methodology to prioritize the severity of events, indicate the person or persons responsible for investigating various levels of events, or indicate the follow up process with responsibility for reporting the findings, recommendations, and/or actions when a root cause analysis or intensive assessment is not performed by the risk manager.</p> <p>2. The hospital Patient Safety Program (approved 2-14) indicated the following: "The Patient Safety Program is part of the overall Performance Improvement Plan...[The] Patient Safety Steering Committee...will be responsible for correcting work processes, and procedures that ...ensure prompt reporting of events or situations of actual or potential patient harm ... [and] ...preserves information critical to understanding the root cause(s) of the error ...errors identified shall be reviewed to determine their cause, and whether the error represents a system problem, a periodic occurrence, or an isolated event ...corrective action is taken to</p> | S 418  |  |                          |  |

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| S 418   | <p>Continued From page 4</p> <p>eliminate the cause of the error ..."</p> <p>3. An administrative document dated 6-30-14 regarding patient 27 indicated that no event investigation was initiated until 7-29-14 after the facility was notified of a complaint investigation.</p> <p>4. During an interview on 7-30-14 at 1055 hours, the oncology unit director A13 indicated they (A13) were on leave at the time of the event involving PT27 and confirmed that they (A13) had not investigated the event after returning to work on 7-08-14 until receiving notice of the complaint investigation on 7-29-14.</p> <p>5. During an interview on 7-30-14 at 1235 hours, risk manager A2 indicated that the Incident Report System should send a follow up reminder and response notice to the involved unit director or manager and send an escalation notice and update bulletin to the chain of command (COC) supervisor. The risk manager A2 confirmed that the policy/procedure Incident Reporting System (approved 2-13) and Patient Safety Program 2014 (approved 3-14) failed to indicate documentation about the follow up reminder/response or escalation notice sent to the unit director or update bulletin sent to the COC supervisor. The risk manager A2 confirmed that a reminder notice was sent to the oncology director A13 on 7-08-14 and an escalation notice was sent to the oncology director A13 on 7-11-14 and confirmed that no update bulletin was sent to the COC executive director of rehabilitation services A12.</p> <p>6. During an interview on 7-30-14 at 1255 hours, risk manager A2 confirmed that no root cause analysis or intensive assessment of the event process involving PT27 had occurred.</p> | S 418  |  |                          |  |

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| S 930   | <p>410 IAC 15-1.5-6 NURSING SERVICE</p> <p>410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>This RULE is not met as evidenced by:<br/>Based upon document review, medical record (MR) review and interview, the nurse executive failed to ensure that the standards of care were maintained and the policy/procedure for medical record documentation was followed for 1 of 9 medical records (patient 37) reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. The policy/procedure Documentation, General Guidelines (approved 4-13) indicated the following: "Patient documentation will accurately and concisely reflect information pertinent to the patient including, but not limited to health problems, treatment provided, and response to care during hospitalization."</li> <li>2. The MR for patient 37 indicated an order on 5-22-14 by the attending physician for the wound/ostomy nurse to evaluate and treat multiple skin issues associated with a diagnosis of lower extremity lymphedema.</li> <li>3. The MR for patient 37 failed to indicate an entry by the wound/ostomy nurse A8 documenting an evaluation with findings and recommendations in response to an order by the attending physician. The MR indicated a</li> </ol> | S 930  |  |                          |  |

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| S 930   | <p>Continued From page 6</p> <p>treatment order on 5-22-14 at 0954 hours by wound/ostomy nurse A8 for skin repair cream to bilateral lower legs two times a day and as needed and no other wound/ostomy nurse entries were identified regarding the complex wound tissue characteristics or changes prior to the date of discharge on 6-02-14.</p> <p>4. During an interview on 7-29-14 at 1545 hours, the director of performance improvement A5 and clinical data manager A4 confirmed that the MR for patient 37 lacked documentation indicating the evaluation with findings by the wound/ostomy nurse A8.</p> <p>5. The MR for patient 37 lacked documentation indicating that nursing staff performed the skin treatment two times a day on 5-22, 5-23, 5-24, 5-26, 5-28, 5-30 and 6-01-14.</p> <p>6. During an interview on 8-01-14 at 1020 hours, the director of performance improvement A5 confirmed that the MR documentation failed to indicate that the skin treatment was performed as ordered on 5-22, 5-23, 5-24, 5-26, 5-28, 5-30 and 6-01-14.</p> | S 930  |  |                          |  |